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# INFORMED CONSENT TO ORGANIC BEHAVIOR CONTROL

**Brent A. Barnhart,\* Michael Lee Pinkerton\*\* and Robert T. Roth\*\*\***

*[T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self protection. . . . His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him or entreating him, but not for compelling him, or visiting him with an evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. John Stuart Mill—1859<sup>1</sup>*

## INTRODUCTION

Absent a clear emergency, any medical treatment imposed without the consent of the subject is considered to be unlawful. In spite of this generally accepted precept, the law continues to employ standards of consent which frequently deny persons labelled “mentally ill” control over the use of organic behavior control procedures.<sup>2</sup>

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1. ON LIBERTY 68 (Pelican ed. 1974).

2. For a brief discussion of the development of the modern concept of informed consent see Comment, *Informed Consent and the Mental Patient: California Recognizes a Mental Patient's Right to Refuse Psychosurgery and Shock Treatment*, 15 SANTA CLARA LAW. 725, 730 n.34 (1975) [hereinafter cited as Comment, *Informed Consent*]; see also note 49 and accompanying text *infra*.

In this article we explore the constitutional and common law tort foundations of consent to organic procedures<sup>3</sup> which are designed to alter or control mentation and/or behavior.<sup>4</sup> Our thesis is twofold: first, a condition precedent to the use of such procedures must be the consent of the person upon whom the procedures are imposed; second, such consent should be defined in factual terms susceptible of empirical analysis. We believe that in determining whether consent is present, legislatures and courts should not impose procedures which evaluate whether such consent is intelligently or rationally exercised.

Currently, the accepted definition of informed consent to treatment is comprised of three elements: (1) *knowledge*—the adequacy of the information conveyed to the prospective treatment subject and his or her comprehension of this information; (2) *volition*—the circumstances allowing for freedom of choice; and (3) *competency*—the capacity to make rational or intelligent judgments.<sup>5</sup>

Consent to organic behavior control procedures, in our view, should be redefined entirely in terms of knowledge and volition; the competency element should be eliminated. We are persuaded that this third element is a value-laden concept which permits the negation of an individual's informed and voluntary choice on the basis of criteria not subject to factual analysis.

For purposes of illustration, we will focus our attention on convulsive and psychosurgical procedures, two of the most extreme and intrusive forms of organic behavior and mentation control. We consider these procedures to be the most drastic; their utilization presents demonstrably radical and permanent

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3. Organic therapy is defined as those treatment modalities which affect or alter through electrochemical or surgical means a person's thought patterns, sensations, feelings, perceptions, and mentation . . . or mental activity generally; or *conditioning* techniques using the effects of electrical or chemical intervention into mental functioning as part of the conditioning program . . . . [T]he expression also includes conditioning using the infliction of severe physical pain . . . . Nonorganic modalities of therapy include a wide variety of techniques described by a plethora of terms, the most inclusive of which is probably "psychotherapy."

Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237, 244 n.8 (1974) [hereinafter cited as Shapiro].

4. "Mentation refers to cognition, understanding, perception, emotion—loosely, any mental functioning or activity." *Id.* at 246 n.14.

5. The terms "competency" and "capacity" are used interchangeably in this context by courts and commentators, and in this article.

alterations of mentation, resulting in serious effects to the subject. Parenthetically, it is suggested that our legal analysis applies with equal validity to all organic procedures for the alteration of mentation or behavior. The effects of various psychoactive drugs, for example, range in intensity from rather mild changes of immediate behavior to dramatic alterations of both mentation and behavior. In our view, the very imposition of such procedures in the absence of informed voluntary consent is an abuse.<sup>6</sup>

Our attempt to redefine the concept of legally valid consent in this context begins with a discussion of the concept of "mental illness"; that discussion gives rise to the competency issue. We then review the constitutional and tort bases for a consent requirement prior to the imposition of organic procedures. Our subsequent analysis of the effects of convulsive and psychosurgical procedures emphasizes their inherently experimental nature. We discuss how recent legislation, case authority and legal scholarship deal with consent, contrasting these concepts with our premise that informed consent should consist solely of knowledge and volition. We conclude with a legislative model consistent with our position.

In the absence of a clear life-threatening emergency situation, any medical procedures without the consent of the subject are unlawful. Yet the law presently persists in employing standards of consent which frequently deny persons adjudicated, or otherwise labelled mentally ill, appropriate control over the imposition of organic procedures to which they may be subjected.

The cost of such an anachronism in human terms is substantial. Many persons deemed not competent to give or refuse consent to organic procedures have been victims of considerable suffering, permanent brain damage, and in some cases, death. Furthermore, the special status of such persons as allegedly incompetent has deprived many of compensation for their injuries.<sup>7</sup>

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6. See Bomstein, *The Forcible Administration of Drugs to Prisoners and Mental Patients*, 9 CLEARINGHOUSE REV. 379 (1975); Comment, *Forced Drug Medication of Involuntarily Committed Mental Patients*, 20 ST. LOUIS U.L.J. 100 (1975); Note, *Mental Health—The Right to Refuse Drug Therapy Under "Emergency Restraint Statutes"*, 11 NEW ENGLAND L. REV. 509 (1976).

7. See, e.g., *Lester v. Aetna Cas. & Sur. Co.*, 240 F.2d 676 (5th Cir. 1957) (legally competent patient was not awarded damages although he claimed that his consent to electroshock treatment was based on inadequate knowledge. His wife's consent, however, was adequate. In the judgment of the patient's wife and psychiatrist, it was

Our argument, in summary, is as follows: considering, (1) the basic disagreement within the scientific community concerning the concepts of "incompetence" and "mental illness"; (2) the strong conviction in the inviolability of the individual which pervades our constitutional framework; (3) the structure of tort law which holds medical procedures performed without the consent of the subject to be actionable at law; and (4) the experimental, unpredictable and often irreversible nature of psychosurgical and convulsive procedures, it is anachronistic and unconscionable to deprive persons, upon whom "mental-patient" status has been imposed, of any meaningful role in decisions concerning their prospective submission to procedures that may result, and are intended to result, in actual and fundamental alteration of the subject's mental state.

#### EFFICACY OF A CORE CONCEPT: "MENTAL ILLNESS"

The concept of "mental illness" is a theoretical construct subject to substantial professional dispute. Nevertheless, the notion of mental illness has been used to justify courses of action whereby the liberty of a person so labeled is restricted, and his or her mentation altered, without personal informed consent. Given the fundamental nature of the individual rights involved, it is imperative that legislative and judicial schemes not be formulated upon an uncritical belief that the concept of "mental illness" has a fixed meaning.

The legal literature is only beginning to reflect the considerable and growing conflict over the meaning of "mental illness" within the social-scientific and psychiatric disciplines. It is crucial that lawyers, legislators, and the courts grasp the depth and extent of that controversy.

The divergent views stem primarily from a basic difference in theoretical orientation within the mental health disciplines.<sup>8</sup> To avoid confusion and to standardize the vocabulary in this article, we will characterize these theoretical schools as

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thought "unwise" to require the patient to consider the hazards entailed); *Farber v. Olkon*, 40 Cal. 2d 503, 254 P.2d 520 (1953) (where hip fractures resulting in permanent deformity sustained by adult incompetent during electroshock treatment held not to be actionable, absent a showing of negligence, where the patient's parent had authority to consent and had consented); *Wilson v. Lehman*, 379 S.W.2d 478 (Ky. Ct. App. 1964) (where consent to electroshock therapy which resulted in injury was presumed from the fact that treatment had taken place at all).

8. The term "mental health disciplines" includes the fields of psychiatry, psychology, social psychology, psychiatric social work, and related disciplines.

*positivistic*<sup>9</sup> and *phenomenological*.<sup>10</sup> In so doing we are aware that this classification is very general, and that within each of these two categories there are several subclassifications which may have little in common with each other beyond a basic orientation.<sup>11</sup>

The positivistic school utilizes the natural science model for its theoretical underpinnings. The psychiatrist nominally adopts an "objective" or "value-free" stance toward the subject matter and proceeds from that Archimedian point. The British psychiatrist, Dr. Ronald Laing, has critically described the positivist school in this manner:

[It is] based on attempts of nineteenth century psychiatrists to bring the frame of clinical medicine to bear on their observations. Thus the subject matter of psychiatry was thought of as mental illness; one thought of mental physiology and mental pathology, one looked for signs and symptoms, made one's diagnosis, assessed prognosis and prescribed treatment. According to one's *philosophical bias*, one looked for the etiology of these mental illnesses in the mind, in the body, in the environment, or in inherited propensities.<sup>12</sup>

The positivist school, then, regards mental illness as an objectively real, diagnosable, and treatable phenomenon. However, within the positivist school itself, there is considerable controversy over the classification and diagnosis of the various types of putative mental illness. While positivist clinicians may be in substantial agreement when diagnosing into very broad categories such as "psychosis" or "neurosis," the general consensus breaks down when more specific classification is attempted.<sup>13</sup>

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9. The philosophical formulation of positivism is contained in L. WITTGENSTEIN, *TRACTATUS LOGICO-PHILOSOPHICUS* (1922). An example of a standard positivistic psychiatry text is L. KOLB, *MODERN CLINICAL PSYCHOLOGY* (8th ed. 1973).

10. The "founding father" of phenomenology is E. Husserl. A good introduction to his writings is *PHENOMENOLOGY AND THE CRISIS OF PHILOSOPHY* (1965). An excellent secondary source is Q. LAUER, *PHENOMENOLOGY: ITS GENESIS AND PROSPECT* (1965). For a psychiatrist's formulation see L. BINSWANGER, *BEING-IN-THE-WORLD* (1973).

11. S. Lyman and M. Scott have illustrated this theoretical split in sociology and social psychology in the introduction to *A SOCIOLOGY OF THE ABSURD* (1970).

12. R. LAING, *THE POLITICS OF EXPERIENCE* 102-03 (Ballantine ed. 1967) (emphasis added) [hereinafter cited as LAING].

13. Some argue that the degree of agreement among clinicians is not even this great. The leading study on this topic is Ash, *The Reliability of Psychiatric Diagnoses*, 44 J. ABNORM. SOC. PSYCHOL. 272 (1949). This and other studies are collected and analyzed in Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping*

The phenomenological school rejects the objectivist natural science model in favor of one that is self-reflective and cognizant of its implicit value assumptions. From this viewpoint psychiatrists become aware of the socio-historical relativity of the concept of "mental illness."<sup>14</sup> While acknowledging that individuals may experience difficulties in living that at times may be quite severe, the phenomenologists generally refuse to regard this phenomenon as an illness in the medical sense. Dr. Thomas Szasz, a professor of psychiatry, has maintained: "Of course, mental illness is not a thing or physical object; hence it can exist only in the same sort of way as do other theoretical concepts. Yet, to those who believe in them, familiar theories are likely to appear, sooner or later, as 'objective truths' or 'facts.'"<sup>15</sup> "The expression 'mental illness' is a metaphor that we have come to mistake for a fact."<sup>16</sup>

From the phenomenological view, there is much concern over the legal and social implications of being adjudicated, or otherwise labeled, "mentally ill." What the positivist would refer to as a diagnosis is to the phenomenologist a political labeling process through which deviant members of society are identified and a particular method of dealing with the labelee is justified.<sup>17</sup>

For the purpose of this article it is not essential to determine which of these views is more scientifically and philosophically sound.<sup>18</sup> The crucial factor is the existence of this essential divergence of views within the scientific community and the danger of building legal conceptualizations on a factual frame-

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*Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974). See also Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA LAW. 400 (1973) [hereinafter cited as Roth *et al.*].

14. See M. FOUCAULT, *MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON* (1965).

15. T. SZASZ, *IDEOLOGY AND INSANITY* 12 (Anchor ed. 1970).

16. *Id.* at 23.

17. See P. BERGER & T. LUCKMAN, *THE SOCIAL CONSTRUCTION OF REALITY* 112-15 (Anchor ed. 1967); LAING, *supra* note 12, at 120-21.

18. Terminology is a problem inherent in a comprehensive and critical review of the coercive imposition of mental patient status; the construction of a new terminology is a complex task beyond the scope of this article. We have adopted terms such as "persons labeled mentally ill" or "inmates" depending on the context: the latter highlights the mental illness label in terms of detention and related side effects such as stigmatization. Our attempt to avoid terminology endorsing the positivist school does not imply acceptance of the phenomenological stance; we merely wish to restrict ourselves to terminology which reflects the empirical data. While reasonable persons may differ as to whether a person is mentally ill or even as to whether such a concept has any factual referent, the labeling process itself, apart from the issue of its alleged validity, is an empirical fact.

work whose legitimacy is stiffly debated by the very disciplines which developed the framework. As Chief Justice (then Judge) Burger, concurring in *Blocker v. United States*, observed:

[N]o rule of law can possibly be sound or workable which is dependent upon the terms of another discipline whose members are in profound disagreement about what those terms mean. . . . This is not simply a matter of experts disagreeing on opinions or on diagnosis, which often occurs, but disagreement at the threshold on what their own critical terms mean.<sup>19</sup>

The actions of the state within the context of government-run mental institutions and prisons raises serious constitutional questions when organic behavior control procedures are administered without the consent of the inmate.<sup>20</sup> The legal questions engendered by the role of the law in this area, however, transcend state action and focus on a more fundamental issue. The acceptance of medical diagnoses and attachment of legal consequences to them<sup>21</sup> has resulted in an off-hand disfranchisement (and in ancient terms, outlawing) of a group of citizens who have committed no crimes.

The traditional legal attitude toward this issue has been that the treatment and confinement of persons labeled mentally ill is within the discretion of the medical profession and does not raise significant legal issues.<sup>22</sup> The Supreme Court has now clearly said that a finding of "mental illness" alone does not constitutionally justify the deprivation of a person's physi-

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19. 288 F.2d 835, 860 (D.C. Cir. 1961).

20. See, e.g., *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973) (state violated a prisoner's civil rights when it gave him a "fright drug" without obtaining his consent).

21. Although some effort is made to keep the concepts of mental illness and competency separate, they are inextricably bound, the former serving as the basis of the latter. For example, expert psychiatric testimony is deemed to have probative value on the issue of legal responsibility for one's acts. Furthermore, FED. R. EVID. 704 allows a psychiatrist to testify as an expert on the ultimate issue of legal responsibility.

22. Petitioner in *O'Connor v. Donaldson*, 422 U.S. 563, 574 n.10 (1975) presented such an argument which was rejected by the Court:

O'Connor argues that, despite the jury's verdict, the Court must assume that Donaldson was receiving treatment sufficient to justify his confinement, because the adequacy of treatment is a "nonjusticiable" question that must be left to the discretion of the psychiatric profession. That argument is unpersuasive. Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present.



cal liberty.<sup>23</sup> A number of state<sup>24</sup> and lower federal<sup>25</sup> courts have come to similar conclusions. Since these developments in the law are relatively recent and leave large areas of concern undiscussed, an examination of the law, its underlying assumptions, and applicability of established doctrines to the specific area of organic behavior control and informed consent to treatment is both appropriate and necessary.

#### LEGAL BASES FOR PROTECTING THE RIGHT TO FREEDOM OF MENTATION

Having briefly explored the essential split within the scientific community over the notion of mental illness, we turn now to the legal bases for protecting mentation. There are at least two independently developed channels of legal thought which support recognition of the protection of an individual's mentation from intrusion by others: constitutional law and tort law.

##### *The Constitutional Basis*

The sanctity of the individual and of his or her mentation lies at the very center of the rights protected by the United States Constitution. The first amendment—embodying multiple aspects of freedom of thought and expression—has been pinpointed by Professor Shapiro as the essential constitutional premise from which freedom of the individual's mental processes achieves recognition as a fundamental right.<sup>26</sup> Shapiro develops the following argument:

- (1) The first amendment protects communications of virtually all kinds, whether in written, verbal, pictorial or any symbolic form, and whether cognitive or emotive in nature.
- (2) Communication entails the transmission and reception of whatever is communicated.
- (3) Transmission and reception necessarily involve mentation on the part of both the person transmitting and the person receiving.

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23. *Id.* at 575. See also *McNeil v. Director, Patuxent Inst.*, 407 U.S. 245 (1971); *Jackson v. Indiana*, 406 U.S. 715 (1971).

24. See, e.g., *People v. Feagley*, 14 Cal. 3d 388, 535 P.2d 373, 121 Cal. Rptr. 509 (1975); *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973), excerpted in 2 PRISON L. RPTR. 433 (1973).

25. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

26. Shapiro, *supra* note 3, at 255-57.

- (4) It is in fact impossible to distinguish in advance mentation which will be involved in or necessary to transmission and reception from mentation which will not.
- (5) If communication is to be protected, *all* mentation (regardless of its potential involvement in transmission or reception) must therefore be protected. . . .
- (6) Organic therapy intrusively alters or interferes with mentation.
- (7) The first amendment therefore protects persons against enforced alteration or interference with their mentation by coerced organic therapy.<sup>27</sup>

This constitutional basis was also articulated in a landmark ruling which declared that involuntarily confined persons could not be used for experimental psychosurgery, *Kaimowitz v. Department of Mental Health*.<sup>28</sup> The *Kaimowitz* court said:

To the extent that the First Amendment protects the dissemination of ideas and the expression of thoughts, it equally must protect the individual's right to generate ideas.

As Justice Cardozo pointed out:

"We are free only if we know, and so in proportion to our knowledge. There is no freedom without choice, and there is no choice without knowledge,—or none that is [not] illusory. *Implicit, therefore, in the very notion of liberty is the liberty of the mind to absorb and to beget,* . . ."

. . . .  
For, if the First Amendment protects the freedom to express ideas, it necessarily follows that it must protect the freedom to generate ideas. Without the latter protection, the former is meaningless.<sup>29</sup>

In our view, however, although the first amendment is clearly an important basis from which freedom of mentation can be inferred to be a fundamental right,<sup>30</sup> it is not the sole

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27. *Id.*

28. Civil No. 73-19434-AW (Wayne County Mich. Cir. Ct. 1973), *excerpted in* 2 PRISON L. RPTR. 443 (1973).

29. *Id.* at 477-78 (emphasis added).

30. It should be noted parenthetically that courts have also recognized that mental patients are entitled to protection from forced treatment where to compel submission to such treatment would violate the freedom of religion. Thus, the Second Circuit held in *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971), that it was a violation of the free exercise clause of the first amendment to compel submission to psychochemotherapy over the religious objections of an involuntarily confined, not legally incompetent, mental patient.

basis.<sup>31</sup> Nor would we argue that the freedom of mentation is merely one of the penumbral or peripheral rights of the first amendment. On the contrary, the fundamental right of freedom of mentation forms a portion of the first amendment's *nucleus*.<sup>32</sup> This nucleus constitutes a common thread running through several of those rights declared to be fundamental. That thread—or common denominator—is the central notion that the *individual* is inviolable. That central notion of the inviolability of the individual has seen development in multiple doctrines protecting the fundamental and personal rights of individuals outside that of the first amendment: the fourth amendment's proscription against unlawful search and seizure; the fifth amendment's privilege against self-incrimination; the recently developed right of privacy;<sup>33</sup> and the more recent underscoring of the ultimate freedom of individual choice regarding decisions which affect one's fate before the law.<sup>34</sup>

As articulated by the Court in *Katz v. United States*,<sup>35</sup> the focus of the fourth amendment's proscription against unreasonable searches and seizures is a concern for the *individual*. Speaking for the Court, Mr. Justice Stewart said: "[T]he Fourth Amendment protects *people*, not places. . . . [What a person] seeks to preserve as private, even in an area accessible to the public, may be constitutionally protected."<sup>36</sup>

As early as 1886, in days when the Court ostensibly was less zealous in protecting personal rights, it underscored violation of the fourth and fifth amendments as invading the sanct-

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31. See N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 388-94 (1971) [hereinafter cited as KITTRIE]. Shapiro also recognizes that the first amendment is not the sole basis for this right; for his discussion on "mental privacy" based on the right to privacy see Shapiro, *supra* note 3, at 273-76.

32. In *Griswold v. Connecticut*, 381 U.S. 479, 482-83 (1965), Mr. Justice Douglas characterized freedom of thought as a peripheral right emanating from the first amendment's penumbra. We do not disagree with Justice Douglas; however, as we conceive the freedom of mentation to be at the *core* of several rights, a nuclear concept is more accurate.

33. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (Texas criminal abortion laws violate the right to privacy, including a woman's qualified right to terminate her pregnancy); *Stanley v. Georgia*, 394 U.S. 557 (1968) (right to receive information and ideas and to be free of governmental intrusions into one's privacy and control of one's thoughts is constitutionally protected); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (Connecticut statute forbidding use of contraceptives violates the right to marital privacy).

34. *Faretta v. California*, 422 U.S. 806 (1975). (Sixth amendment guarantees that a state criminal defendant has the right to defend himself without counsel when he voluntarily and intelligently elects to do so).

35. 389 U.S. 347 (1967).

36. *Id.* at 351-52 (emphasis added).

ity of the *individual*:<sup>37</sup> "It is not the breaking of his doors, and the rummaging of his drawers, that constitutes the essence of the offense; but it is the invasion of his indefeasible right of personal security, personal liberty, and private property . . . ."<sup>38</sup>

The culmination of the Supreme Court's concern for the sanctity of the individual has been its recent recognition and development of an independent fundamental "right of privacy" not specifically enumerated in the Bill of Rights. The right of privacy draws on several constitutional provisions which specifically recognize the inviolability of the individual as constitutionally protected.

In his famous dissent in *Olmstead v. United States*,<sup>39</sup> Mr. Justice Brandeis gave the Court's first utterance of a right to privacy, citing the fourth amendment's right against unreasonable search and seizure and the fifth amendment's right against self-incrimination:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man.<sup>40</sup>

But not until *Griswold v. Connecticut*<sup>41</sup> in 1965 did the Supreme Court adopt a fundamental right of privacy as the constitutional basis for deciding an issue before the Court. In *Griswold*, Mr. Justice Douglas referred not only to the first, fourth and fifth amendments, but also to the third amendment's proscription against quartering soldiers "in any house" in time of peace without consent of the owner.<sup>42</sup> And in a concurring opinion in *Griswold*, Mr. Justice Goldberg relied on the ninth amendment's reservation of "non-enumerated" rights to

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37. *Boyd v. United States*, 116 U.S. 616, (1886); see also *McNeil v. Director, Patuxent Inst.*, 407 U.S. 245, 252 (1971) (Douglas, J., concurring).

38. *Boyd v. United States*, 116 U.S. 616, 630 (1886).

39. 277 U.S. 438 (1927).

40. *Id.* at 478 (emphasis added).

41. 381 U.S. 479 (1965).

42. *Id.* at 484.

the people as supportive of the right to privacy.<sup>43</sup>

Thus, the right of privacy now recognized by the United States Supreme Court reflects a recognition of a notion common to several provisions of the Bill of Rights, but philosophically more basic than those rights. In our view, the search must go even further. There is a need to look beyond the right of privacy to a *nucleus* which joins not only the right of privacy and the first amendment, but all situations in which the Court's disposition reflects its response to unjustifiable invasions of the individual.<sup>44</sup>

In California, what is nationally an implicit right of privacy became express when that right was added, by voter initiative, to the "inalienable rights" enumerated in the state constitution.<sup>45</sup> The broad interpretation of that new constitutional provision by the California Supreme Court<sup>46</sup> strongly suggests that freedom of mentation—one's very personality and autonomy—is even more basic than the right to privacy. As the California Supreme Court declared in *White v. Davis*, affirming the concept articulated by Justice Brandeis: "The right of privacy is the *right to be left alone*. It is a fundamental and compelling interest. It protects our homes, our families, our thoughts, our emotions, our expressions, our personalities, our freedom of communion and our freedom to associate with the people we choose."<sup>47</sup> Underlying the "right to be left alone" is a right to think in a certain fashion and a right to *be* a certain person. More fundamental than the right to be left alone is the right to remain as one is. It is not the irritation and threat of external manipulation of one's personal life, but the external

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43. *Id.* at 487-96.

44. See, e.g., the Court's expressed disfavor for unwarranted intrusion into human bodies: *Rochin v. California*, 342 U.S. 165 (1952); *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250 (1891); *Huguez v. United States*, 406 F.2d 366, 382 n.84 (9th Cir. 1968); and the Court's support of the freedom of individuals to make decisions which affect their ultimate fortune in court proceedings: *Faretta v. California*, 422 U.S. 806 (1975).

45. CAL. CONST. art. I, § 1: "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy."

46. See, e.g., *Valley Bank v. Superior Court*, 15 Cal. 3d 652, 542 P.2d 977, 125 Cal. Rptr. 553 (1976); *White v. Davis*, 13 Cal. 3d 757, 533 P.2d 222, 120 Cal. Rptr. 94 (1975).

47. 13 Cal. 3d 757, 774, 533 P.2d 222, 233, 120 Cal. Rptr. 94, 105 (1975) (citing a statement drafted by proponents of the referendum to change the wording of CAL. CONST. art. I, § 1) (emphasis added).

compulsion to change one's personality that constitutes the ultimate invasion of one's freedom.

To date, however, constitutional protection of the individual's freedom of mentation remains unarticulated. Whether we proceed from the first amendment, the right of privacy, or any other well-recognized constitutional doctrine,<sup>48</sup> it is incumbent upon the legal community to recognize the common denominator of the inviolability of the individual. The recognition of a constitutional freedom of mentation would bring into focus the fundamentalness of rights breached by unconsented organic behavior control and the incongruity of the failure of the law to assert its protection over the most basic of individual rights.

### *The Tort Basis*

The individual's right to protection of his or her autonomy—his or her processes of mentation—from intrusion by others also draws strong support from traditional tort law. There exists a well-articulated body of law dealing with unlawfulness of medical treatment performed without the informed consent of the patient.<sup>49</sup>

For example, in a very thorough explanation of the informed consent doctrine, the California Supreme Court in *Cobbs v. Grant* carefully explained the clear line which separates the authority and expertise of the physician from the patient's ultimate decision to accept treatment:

Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected.

A medical doctor, being the expert, appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation

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48. KITTRIE, *supra* note 31, at 388-94.

49. Traditionally medical treatment performed without consent of the subject has been regarded as a battery. W. PROSSER, *THE LAW OF TORTS* § 32, at 165 (4th ed. 1971). For a discussion of modern concepts see authorities cited in Annas & Glantz, *Psychosurgery: The Law's Response*, 54 BOSTON U.L. REV. 254-55 n.31 (1974); Waltz & Scheuneman, *Informed Consent to Therapy* 64 NW. U.L. REV. 628 n.1 (1970).

and decision is a nonmedical judgment reserved to the patient alone.<sup>50</sup>

The same concept is embodied in Harper and James' treatise on tort law:

The very foundation of the doctrine [of informed consent] is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish.<sup>51</sup>

Thus, the substantiality of the individual's right at common law to be free of intrusions affecting his or her physical body and personal integrity is clear. It follows that this right should also protect, without restriction and without qualification, the very core of the individual—one's mind and personality. As two commentators noted,

Anglo-Saxon law does not recognize—that is to say, it entirely disallows—nonconsensual treatment . . . . In other words, unconsented surgery is, in the eyes of the law, tantamount to attack with a knife. There is no reason, from a legal point of view, to regard unconsented psychiatric interventions—whether they consist of lobotomy, electroshock, hospitalization, or psychotherapy—in a different light.<sup>52</sup>

Yet, as we shall discuss, by means of a curious blend of Catch-22 and well-meaning paternalism, such tort law protection is substantially without effect when the focus of the "treatment" is one's mind and personality.

#### DEVELOPING AREAS: INVOLUNTARY CONFINEMENT AND THE RIGHT TO REFUSE PSYCHIATRIC PROCEDURES

Although the law has begun to move toward a reappraisal of mental patient status and the implications of the labeling process by which it is imposed, progress thus far has been halt-

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50. 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

51. 2 F. HARPER & F. JAMES, JR., *THE LAW OF TORTS* 61 (1968 Supp.).

52. Alexander & Szasz, *From Contract to Status via Psychiatry*, 13 SANTA CLARA LAW. 537, 548 (1973) [hereinafter cited as Alexander & Szasz].

ing; while moving with determination in one area, the law has neglected essential rights in others.

In the area of involuntary confinement, courts and legislatures<sup>53</sup> have begun to scrutinize previously unquestioned doctrines that all too often have been used as tools for shelving the constitutional and other legal rights of persons labeled mentally ill.<sup>54</sup> Recently, the Supreme Court in *O'Connor v. Donaldson* held that a "finding of 'mental illness' alone" does not constitutionally justify involuntary confinement.<sup>55</sup> In 1967, California nominally abolished *indefinite* involuntary confinement.<sup>56</sup> For all such advances, however, and despite a significant reduction in the number of persons involuntarily confined in California's mental institutions, people are still detained involuntarily even in the absence of a finding that they are dangerous to self or others. Through the use of the conservatorship mechanism and back-to-back commitments—what has been called a "revolving door" phenomenon—the number of persons involuntarily detained as mental patients who pose no threat to society remains substantial.<sup>57</sup>

Emerging from the concern for the rights of persons involuntarily confined is the infant doctrine of the "right to treatment." The courts have declared that persons have a right to treatment if involuntarily confined, and if no treatment is pro-

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53. For a discussion of statutes dealing with the involuntary confinement of persons labeled mentally ill see Roth *et al.*, *supra* note 13, at 412-16.

54. See notes 24 and 25 *supra*.

55. 422 U.S. 563, 575. The court noted,

[a] finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that the term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

*Id.* at 575.

56. CAL. WELF. & INST. CODE § 5325 *et seq.* (West Supp. 1976). The Lanterman-Petris-Short Act further provides that the confined person is entitled to certain specific rights, including the right to refuse convulsive procedures and psychosurgery. See also E. BARDACH, *THE SKILL FACTOR IN POLITICS: REPEALING THE MENTAL COMMITMENT LAWS IN CALIFORNIA* (1972); CAL. LEGISLATURE, ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, SUBCOMM. ON MENTAL HEALTH SERVICES, *THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA* (1972).

57. Coleman, Lerner, Schwartz & Roth, *Proposal for a Task Force on the Civil Rights of Mental Patients* (1975). This report, submitted to the California Department of Health, is based on the experience of three attorneys and a psychiatrist. The authors cited apparently extensive violations of the law and recommended further investigation [on file with the Center for the Study of Legal Authority and Mental Patient Status, Hartford, Conn.].



vided, they must be released.<sup>58</sup> Whatever the benevolent intent of the "right to treatment" doctrine, this concept could ultimately cause problems. It is presently accepted that once a person is declared incompetent or incapacitated, his or her informed consent to treatment is no longer possible. What is generally not considered is that there may be no benefit conferred on a recipient who does not desire such treatment.<sup>59</sup> Furthermore, a number of treatment modalities involve secondary or even primary deleterious effects. Thus, while the allegedly incompetent person is deemed to have a right to treatment, the critical concept of the *right to refuse psychiatric procedures* has received wholly inadequate attention.<sup>60</sup>

The inherent danger in the "right to treatment" doctrine is that it can be turned into a license to administer psychiatric procedures without informed consent. For example, one physician has argued that,

Legal restrictions on or prohibition of a medical or surgical procedure may accomplish the goal of protecting some of the human rights of patients. But, it also can deny some

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58. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1967) (based on local statutes); *Wyatt v. Stickney*, 325 F. Supp. 781 (N.D. Ala. 1971). See Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960) (first enunciation of the argument that persons involuntarily committed to mental institutions have the right to treatment—that an institution either has to provide adequate treatment or release the patient, since confinement without meeting its purpose, whether medical, corrective or rehabilitational, constitutes deprivation of liberty without due process of law); Editorial, *A New Right*, 46 A.B.A.J. 516 (1960); Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974), and cases cited therein. See generally *Hearings on S. 935 Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 88th Cong., 1st Sess. (1963); *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. (1961).

See also Ladimer, *Rational Psychopharmacotherapy and Judicial Interpretations of the Right to Treatment: An Outline*, in *RATIONAL PSYCHOPHARMACOTHERAPY AND THE RIGHT TO TREATMENT* (F. Ayd, Jr., ed. 1975); *THE MENTALLY ILL AND THE RIGHT TO TREATMENT* (G. Morris ed. 1970).

59. To appreciate the abuses to which a "right to treatment" approach lends itself, it should be noted that the "treatment" accorded inmates is often described as "milieu therapy"—a euphemism for stark custodial confinement. *O'Connor v. Donaldson*, 422 U.S. 563, 569 (1975). See also *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1967); *People v. Feagley*, 14 Cal. 3d 388, 535 P.2d 373, 121 Cal. Rptr. 509 (1975). A commentator has noted that the adequacy of treatment is an amorphous and intangible concept, and furthermore, is an easy therapeutic claim for an institution to assert, yet most difficult for a patient to refute. Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782 (1969).

60. For an excellent discussion of the traditional constitutional basis for the right to refuse treatment see Comment, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMP. L.Q. 354 (1975).

very sick people their right to opportunities to have their health improved, their illnesses better treated, and their death prevented.<sup>61</sup>

Another doctor has declared:

. . . I think one should go the extreme of always explaining to a patient if he is going to get electroshock, why he is going to get it and what it is going to be like and so forth and so on. But as far as getting permission from the patient is concerned, this is not necessary.<sup>62</sup>

Without questioning the sincerity of these professionals, it must be observed that there is a potential conflict when a physician's judgment collides with an individual's right to refuse psychiatric procedures. The law must take account of more than a physician's sincerity, diligence and professional competence. There must also be an assessment in each instance of the views and legal rights of the prospective subject. A bare "right to treatment" does not provide that perspective.

Our system guarantees the right to risk making the wrong decision. In *Faretta v. California*, the Supreme Court declared a limit to paternalism and observed that personal decisions belong to those who will sustain their consequences: "[W]hatever else may be said of those who wrote the Bill of Rights, surely there can be no doubt that they understood the inestimable worth of free choice."<sup>63</sup> Surely when we accord peo-

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61. Ayd, Jr., *Treatment-Resistant Patients: A Moral, Legal and Therapeutic Challenge*, in *RATIONAL PSYCHOPHARMACOTHERAPY AND THE RIGHT TO TREATMENT* 41 (F. Ayd, Jr., ed. 1975). Further enunciation of this thinking is present in this statement by Dr. Ayd:

In the past 25 years, and particularly since I became engrossed in psychopharmacotherapy in 1952, I have treated, or as a consultant, I have guided the treatment of many apparently and truly treatment-resistant patients. Happily, many of these people have been helped substantially. This has happened because of new therapies and because I have firm convictions that *a sick person has a moral and legal right to treatment, that a doctor has a moral obligation to be therapeutically persistent and innovative, and that physicians and patients are morally justified in taking legitimate risks in their joint efforts to restore health.*

*Id.* at 37 (emphasis added).

62. *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary* 87th Cong., 1st Sess., pt. 1, at 155 (1961) (statement of Dr. Guttmacher).

63. 422 U.S. 806, 833-34 (1975). In the last decade there has been evidence of growing distrust among appellate courts towards paternalistic doctrines based on a "treatment" rationale and towards programs created ostensibly to "help" the offender or deviant. See, e.g., *In re Gault*, 387 U.S. 1 (1967); *People v. Feagley*, 14 Cal. 3d 338, 535 P.2d 273, 121 Cal. Rptr. 509 (1975); *In re Gary W.*, 5 Cal. 3d 296, 486 P.2d 1201,

ple a right to treatment we must assure them the right to refuse.

### CONSENT AND MEDICAL EXPERIMENTATION

If there exists a fundamental right to mentation, it necessarily follows that medical and surgical procedures which are intended to affect mentation, thought, and personality require greater constitutional scrutiny and review than do other procedures.<sup>64</sup> It is equally apparent that when medical and surgical procedures involve such high risks and uncertain benefits as to be essentially experimental in nature,<sup>65</sup> the informed consent of the intended subject becomes an absolute condition precedent to the utilization of that procedure.

In this section we seek to demonstrate that psychosurgical and convulsive procedures, as the most drastic forms of organic behavior controls, are such experimental procedures.<sup>66</sup> We then

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96 Cal. Rptr. 1 (1971). Contrast such skepticism with the Supreme Court's more hopeful view of such an approach in *Robinson v. California*, 370 U.S. 660 (1962).

64. In this section we have drawn heavily from Brief for Lawyers Committee to Support AB 4481, as *Amicus Curiae*, *Aden v. Younger*, 57 Cal. App. 3d 662 (1976). See 13 DUQUESNE L. REV. 673-936 (1975) for a symposium on medical experimentation where many diverse viewpoints are presented.

65. The legal determination of whether or not a given procedure is experimental is not a question to be answered by resort to convention. That a given modality is generally accepted by practitioners and has been widely used does not in itself resolve the issue. See note 66 *infra*.

The empirical evaluation of treatment results presents two significant problems. First, determination of "improvement" and "benefit" tends to be highly subjective. Second, studies to date are not supported by an adequate scientific foundation. For instance, the only available data on psychosurgery is provided by psychosurgeons, chiefly in medical journal articles. The surgeons themselves evaluate post-operative results, using purely normative standards such as "improves," "much improved," and "worse." There are no control groups and little or no effort is made to measure the placebo effect of the operation or the effect of the special care and services rendered in conjunction with surgery. Breggin, *The Return of Lobotomy and Psychosurgery*, 118 CONG. REC. 5567, 5573 (1972).

A similar situation exists with regard to convulsive procedures. "[T]he data is simply unsound with regard to how often it works, and most particularly with regard to the side effects. Therefore, the patient cannot make a very meaningful consent . . . if they do not know what the risks are." Letter from Lee Coleman, M.D., psychiatrist, to Robert Roth (October 29, 1976) [on file at SANTA CLARA L. REV. and the Center for the Study of Legal Authority and Mental Patient Status, Hartford, Conn.] [hereinafter cited as Coleman Letter].

66. In this discussion it may be helpful to make an explicit statement of our criteria for determining the experimental or nonexperimental nature of a procedure. The essential criterion is whether or not there has been sufficient evidence and research to show that the ratio of benefits to risks is sufficiently well established that the prospective subject has enough information to assess the predicted outcome within reasonable limits. If there has not been enough research, or if research has shown that the possible benefits are not very high compared to the risks, or if the results of research

discuss why informed consent is requisite before administering an experimental procedure on either a confined or nonconfined person. We also present our position that, even in the event these procedures should cease to be experimental in nature, informed consent would nevertheless be constitutionally mandated as a precondition to their implementation.

### *Psychosurgical Procedures*

"Psychosurgery" has been defined as "the surgical removal or destruction of brain tissue or the cutting of brain tissue to disconnect one part of the brain from another, with the *intent of altering* [thoughts and/or] behavior."<sup>67</sup> Furthermore, psychosurgery is usually "performed in the absence of direct evidence of existing structural disease or brain damage."<sup>68</sup> There is considerable professional disagreement over

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are too inconclusive to estimate outcome within reasonable limits, then we would characterize the procedure as *experimental*. Coleman Letter, *supra* note 65.

We consider this characterization to be critical in view of the California Court of Appeal's decision in *Aden v. Younger*, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535, *as modified*, 58 Cal. App. 3d 990a, 59 Cal. App. 3d 174d (1976). This case involved a challenge to the constitutionality of California legislation regulating the administration of psychosurgical and convulsive procedures. The court stated at the outset that the case involved "*consent . . . , not the efficacy of treatments*" and on that basis did not consider it necessary to hold an evidentiary hearing on the *factual nature* of the procedures in question. *Id.* at 670-71. Yet later in the opinion, in distinguishing between regulations aimed at psychosurgery and those regarding convulsive procedures, the court apparently found the *factual nature* of the procedures involved to be dispositive of the legal issues. Thus, regulations concerning psychosurgical procedures were deemed legitimate in light of the "hazardous, experimental nature of psychosurgery" while regulations regarding convulsive procedures—an "almost identical" regulatory scheme in the eyes of the court—were struck down essentially on the basis that "'shock treatment,' or more precisely ECT, is not an experimental procedure, nor are its hazards as serious as those of psychosurgery." *Id.* at 683-84.

We disagree with the court's characterization of convulsive procedures as being non-experimental, on the basis of the criteria explained above, and our discussion accompanying notes 67-96, *infra*.

67. NATIONAL INSTITUTE OF MENTAL HEALTH, U.S. DEP'T OF HEALTH, ED. & WELF., *PSYCHOSURGERY: PERSPECTIVE ON A CURRENT ISSUE* 1 (1973) [hereinafter cited as DHEW] (emphasis added).

68. *Id.* For a description of psychosurgical techniques see Greenblatt, *Psychosurgery*, in *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* 1291-95 (A. Friedman & H. Kaplan eds. 1967) [hereinafter cited as Greenblatt].

Psychosurgery is distinguished from neurosurgery in that the former encompasses "operations on the brain for the purpose of altering thoughts or feelings or behavior for which there is no established physical cause. There is no brain disease which is being treated, in contrast to neurosurgery, where there is a tumor or abscess . . . physical lesions of the brain . . ." which are operated upon. Testimony of Lee S. Coleman, M.D., *Hearings on AB 1032 Before the California Assembly Permanent Subcomm. on Health and Developmental Disabilities*, (1975) (on file at the office of

what portion of the brain should be operated upon to affect a given type of thought or behavior. Researchers for the Department of Health Education and Welfare have stated:

We believe that knowledge and understanding of the relation between the brain and behavioral abnormalities and of the optimal treatment of such abnormalities are still in *very early* stages. Even though there has been a vast amount of recent animal research our knowledge of brain function is still insufficient for a clear understanding about what parts of the brain control what behaviors.<sup>69</sup>

The efficacy of psychosurgery, as well as the mechanism by which it causes its effects, is in serious question.<sup>70</sup> While medical journals contain many specific case histories of psychosurgical operations, there have been few if any systematic, methodologically sound, comparative studies performed to determine whether psychosurgery is effective in alleviating alleged psychiatric disorders.<sup>71</sup>

In 1972 Dr. Peter Breggin, after an extensive review of the medical literature on this point, concluded:

Scientifically, lobotomy and psychosurgery have no rational or empirical basis. Empirically, no study has ever been done involving matched control groups. That is, no one has ever taken two similar groups and subjected one to surgery and left one alone for comparison. This is the scientific method at its best and it is totally absent from the hundreds of pro-lobotomy articles in both the first and second waves of psychosurgery.

Three controlled studies have been done retrospectively matching as nearly as possible the surgical groups and the regular [psychiatric] hospital population upon which no surgery was done. . . . In all three studies lobotomy was found to have no beneficial effect whatsoever . . . .<sup>72</sup>

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the Subcommittee, University of the Pacific, McGeorge School of Law Library, Sacramento, California, and Yale University Law Library, New Haven, Connecticut and SANTA CLARA L. REV.).

A very helpful definition of psychosurgery for regulatory purposes is contained in CAL. WELF. & INST. CODE § 5325 (g) (West Supp. 1976).

69. DHEW, *supra* note 67, at 8 (emphasis added). See also discussion in *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973) excerpted in 2 PRISON L. RPTR. 433, 473-74 (1973).

70. *Id.*

71. Breggin, *The Return of Lobotomy and Psychosurgery*, 118 CONG. REC. 5567, 5575 (1972).

72. *Id.* at 5567 (citations omitted). For an example of such a study, see McKenzie

It is clear, moreover, that psychosurgery has serious deleterious effects. By definition, when psychosurgery is performed, the brain is physically damaged and brain cells are destroyed. Any damage to the brain of this sort is irreversible, as brain cells are incapable of regeneration. These are inherent aspects of a "successful" psychosurgical procedure. Furthermore, studies indicate that psychosurgery may produce considerable and perhaps even progressive deterioration of the treatment subject's personality.<sup>73</sup> It has been found that psychosurgery frequently and unpredictably results in a general flattening of emotional responses,<sup>74</sup> impairment of the ability to think conceptually,<sup>75</sup> a loss of creativity,<sup>76</sup> and reduction in drive.<sup>77</sup> In some cases the post-operative patient may experience extreme fluctuations in emotions within a short period of time.<sup>78</sup> Physiological effects may also occur, including postoperative grand mal seizures,<sup>79</sup> blindness,<sup>80</sup> and death.<sup>81</sup>

### *Convulsive Procedures*

"Convulsive procedure" is a term which includes, but is not limited to, electroshock therapy (ECT), insulin coma therapy, and other convulsive procedures such as inhalation or intravenous injection of hexafluorodiethyl ether.

The various convulsive procedures have one aspect in common: the treatment causes the patient to undergo a seizure of grand mal intensity. This seizure, according to its proponents, results in beneficial psychological changes in the patient. There is no definitive or generally accepted theory of convulsive procedures: the mechanism by which a seizure causes its var-

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& Kaczanowski, *Prefrontal Leukotomy: A Five-Year Controlled Study*, 91 CAN. MED. ASS'N J. 1193 (1964). Since the supposed therapeutic benefits occur in all forms of psychosurgery, these studies, although limited to lobotomy, are relevant to all psychosurgical techniques.

73. See generally Greenblatt, *supra* note 68, at 1293-94.

74. Breggin, *The Second Wave*, 57 MENTAL HYGIENE 10, 12 (1973) [hereinafter cited as Breggin].

75. Greenblatt, *supra* note 68 at 1293.

76. Freeman, *Psychosurgery*, in 2 AMERICAN HANDBOOK OF PSYCHIATRY 1526, 1534-35 (S. Arieti ed. 1959).

77. Greenblatt & Myerson, *Medical Progress: Psychosurgery*, 240 NEW ENGLAND J. MED. 1006, 1014 (1949) [hereinafter cited as Greenblatt & Myerson].

78. *Id.* at 1015.

79. *Id.* at 1012.

80. Breggin, *supra* note 74, at 11, reports such a case.

81. See, e.g., Greenblatt & Myerson, *supra* note 77, at 1012, where the death rate was reported to be from one to four percent.

ious effects is unknown, and theories regarding such mechanisms are highly speculative.<sup>82</sup>

The efficacy of convulsive procedures in producing the effects desired by the administering party is, moreover, subject to serious question.<sup>83</sup> Most studies on the effects of convulsive procedures are equivocal because of a failure to employ sound scientific methodology.<sup>84</sup> It is important to note the many sound studies which report that persons treated with convulsive therapy did not improve significantly more than control

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82. There exists no definitive or generally accepted theory of shock treatment. Krouner, *Shock Therapy and Psychiatric Malpractice: The Legal Accommodation to a Controversial Treatment* 2 FORENS. SCI. 397, 399-400 (1973) [hereinafter cited as Krouner]. One investigator noted that: "In 1948, Gordon was able to write a paper entitled 'Fifty shock therapy theories.' Since then, theories have continued to multiply . . . . It is . . . obvious that none of the theories . . . so far is near to being considered adequate." Miller, *Psychological Theories of ECT: A Review*, 113 BRIT. J. PSYCHIAT. 301, 307 (1967). This researcher suggests three reasons for the failure of theoretical attempts to explain and justify shock treatment: (1) organic causes, if any, of mental disorders remain largely unknown; (2) systematic attempts to explore the effects of shock treatment are rare, and there is little or no well-established information on these effects; and (3) many theories have been so speculative that it is difficult or impossible to test them. *Id.* at 307, 308.

Several of the major shock therapy theories are ethically questionable. For example, one theory argues that it is the fear induced by the procedure which is the effective agent. *Id.* at 303. Under a second theory, known as the "regressive" or "depatterning" theory, the purpose of shock treatment is to reduce the subject to infantile levels in order to structure his or her development. *Id.* at 304. In one reported experiment, the doctors shocked subjects twice daily until "depatterning" occurred; that is, until patients were in a state of helplessness, apathy and confusion, exhibiting memory loss, speech alterations, and gross disorientation. Cameron, Lohrenz & Handcock, *The Depatterning Treatment of Schizophrenia*, 3 COMP. PSYCHIAT. 65 (1962).

It is interesting to note that the means by which psychosurgical and convulsive procedures achieve their effects are not clearly established. Although it is not understood how many other bona fide treatments achieve their results (*See Coleman Letter, supra* note 65), we maintain that the uncertainties regarding causality of these procedures highlight the issue of their unpredictability.

There are at least fifty theories of how convulsive procedures achieve their effects. Krouner, *supra*, at 399. Particularly disturbing among the many theories of how convulsive procedures work is the suggestion that brain damage is the effective mechanism, (Coleman Letter, *supra* note 65) and the conclusion of a neurologist that the causation of amnesia is the means by which convulsive procedures "work." J. FRIEDBERG, *SHOCK TREATMENT IS NOT GOOD FOR YOUR BRAIN* (1976). These two theories are of course mutually consistent and may perhaps be viewed as alternative conceptualizations of a single theory. Dr. Coleman contends that there is no evidence to support the belief that it is the seizure which produces such results and concludes that "[a]ny procedure which damages the brain, including a strong blow with a 2x4, would be just as effective" as convulsive procedures. Coleman Letter, *supra* note 65.

83. *See, e.g.,* Salzman, *An Evaluation of Shock Therapy*, 103 AM. J. PSYCHIAT. 669 (1947).

84. Riddell, *The Therapeutic Efficacy of ECT: A Review of the Literature*, 8 ARCH. GEN. PSYCHIAT. 546, 553-56 (1963).

groups whose members did not receive such treatment. An exhaustive review of the literature recently concluded:

Despite all the studies, the effectiveness of ECT [electroconvulsive therapy] remains unproven . . . . The glowing claims of success for ECT have followed the cyclical pattern of most therapeutic fashions in psychiatry. The discoverer of the treatment boasts the best results for the broadest indications, while subsequent researchers find diminished success and fewer and fewer indications.<sup>85</sup>

There are also significant harmful effects which obtain from the utilization of convulsive procedures. A commentator discussing one form of convulsive treatment has extended this caveat:

Since dangerous, and even fatal complications may readily occur, it is essential that both physician and nurse possess sufficient experience and skill to enable them to recognize and deal immediately with emergency situations. Even though both possess these qualities the mortality rate will be from 0.5 to 1 per cent.<sup>86</sup>

The simplest and most treatable complication of convulsive procedures is bone fracture resulting from the muscular contractions which occur during the induced seizure. Although the risk of bone fracture has been reduced with the utilization of pharmacological agents which relax muscles and anesthetize the treatment subject,<sup>87</sup> "the statement remains valid that fractures are entirely unpredictable."<sup>88</sup> It should be noted that while these adjuvants reduce the frequency of bone fracture, their use results in other problems. For example, the agents increase the risk of cardiovascular complications, respiratory arrest and aspiration pneumonia.<sup>89</sup>

In addition to these physical effects, there are also serious psychological complications which occur more frequently. The most common are "postconvulsive restlessness, confusion, psychotic episodes, startle reactions and memory impairment . . . ."<sup>90</sup> Memory loss may be permanent and severe.<sup>91</sup>

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85. Friedberg, *Electroshock Therapy: Let's Stop Blasting the Brain*, PSYCHOLOGY TODAY, Aug., 1975, at 98 [hereinafter cited as Friedberg].

86. L. KOLB, MODERN CLINICAL PSYCHIATRY 649 (8th ed. 1973).

87. For example, succinylcholine and ultra-short-acting barbiturates are presently being utilized to control convulsions. Krouner, *supra* note 82, at 402.

88. *Id.* at 403.

89. Beresford, *Legal Issues Relating to Electroconvulsive Therapy*, 25 ARCH. GEN. PSYCHIAT. 100, 101 (1971).

90. Krouner, *supra* note 82, at 403.

Regarding the distinction between physiological and psychological effects, it is



Recent psychological testing of treatment subjects and control groups has suggested that the source of these and other psychological effects of convulsive procedures may be brain damage,<sup>92</sup> perhaps permanent brain damage.<sup>93</sup> Some scientists have argued that the brain damage caused by convulsive procedures is analogous to,<sup>94</sup> or greater than, the brain damage caused by psychosurgery.<sup>95</sup>

The medical literature indicates the extent and degree to which researchers are questioning the efficacy and advisability of psychosurgical and convulsive procedures. There are staunch supporters of these treatment modalities, but there is much professional disagreement over what these procedures

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suggested that such phenomena as post-convulsive restlessness, confusion, and memory impairment are psychological manifestations of the brain damage which results from the procedures. "Restlessness, confusion and memory impairment are classical signs of brain damage. Therefore, they are best considered as physical complications which also happen to show certain psychological manifestations." Coleman Letter, *supra* note 65, at 2-3.

91. Goldman, Gomer & Timpler, *Long-Term Effects of Electroconvulsive Therapy upon Memory and Perceptual-Motor Performance*, 28 J. CLINICAL PSYCHOL. 32, 33 (1972) [hereinafter cited as Goldman]; Lewis & Maher, *Neural Consolidation and Electroconvulsive Shock*, 72 PSYCHOL. REV. 225 (1965).

Although it is usually stated that these mental complications are temporary, lasting only a few days to a week, some recipients of convulsive therapy have a different view. In Roueche, *Annals of Medicine: As Empty as Eve*, 50 THE NEW YORKER, Sept., 9, 1974, at 96, is reported the case of a financial analyst-economist who underwent a series of eight electroshock treatments early in 1973. She was assured that the post-treatment amnesia she complained of would be temporary. Unfortunately, it was not. After a period of convalescence she returned to work and discovered that "all my beloved knowledge, everything I had learned in my field during 20 years or more, was gone. I'd lost the body of knowledge that constituted my professional skill. . . . But it was worse than that. I felt that I'd lost myself. . . ." Her attempt to regain memory through psychiatric treatment was unsuccessful; the treating psychiatrist was of the opinion that her memory loss was caused by brain damage. Needless to say, she could not retain her job as an economist. She obtained a disability retirement and was doing low level clerical work when the article went to press in the latter part of 1974. While permanent memory loss may not be a typical side effect, the fact remains that it does occur. She also lost the capacity to learn efficiently. Impaired learning ability of at least a temporary nature is well documented. See sources indexed under *Complications, learning impairment*, in M. GELLER, PUBLIC HEALTH SERVICE, U.S. DEPT. OF HEALTH, ED. & WELF., STUDIES ON ELECTROCONVULSIVE THERAPY 1939-1963: A SELECTED ANNOTATED BIBLIOGRAPHY (Public Health Service Pub. No. 1447, 1966) [hereinafter cited as GELLER].

92. See sources cited in GELLER, *supra* note 91.

93. Goldman, *supra* note 91, at 32.

94. Salzman, *An Evaluation of Shock Therapy*, 103 AM. J. PSYCHIAT. 669, 672 (1947).

95. *From Lobotomy to Physics to Freud—An Interview with Karl Pribram*, 5 AM. PSYCHOL. ASS'N MONITOR, Sept.-Oct., 1974, at 9. Some physicians are advocating the total abolition of psychosurgery (Breggin, *supra* note 74) and shock therapy (Friedberg, *supra* note 85).

accomplish. It is clear that there are serious and often unpredictable effects, both primary and secondary, which may result from their utilization. We are thus led to the conclusion that convulsive procedures, as well as psychosurgical, may appropriately be categorized as experimental.<sup>96</sup>

### *Consent to Experimental Treatments That Alter Mentation*

The question of human experimentation has attracted extensive discussion within both the medical<sup>97</sup> and legal<sup>98</sup> professions. Despite persistent arguments by medical researchers that psychosurgical experimentation is essential for understanding the human brain and human behavior,<sup>99</sup> the growing trend in the law is directed toward restricting the availability of involuntarily confined populations as human subjects.<sup>100</sup> In

96. See note 65 *supra*.

97. American Medical Association, *Principles of Medical Ethics*, in *Supplementary Report of the Judicial Council*, 132 J.A.M.A. 1090 (1946); AMERICAN MEDICAL ASSOCIATION, *ETHICAL GUIDELINES FOR CLINICAL INVESTIGATION* (1966); World Medical Association, *Code of Ethics (Declaration of Helsinki)*, reprinted in 2 BRIT. MED. J. 177 (1964).

98. See citations in *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County Mich. Cir. Ct., 1973) excerpted in 2 PRISON L. RPTR. 433 (1973). The court in *Fortner v. Koch*, 272 Mich. 273, 282, 261 N.W. 762, 765 (1935), stated:

We recognize the fact that if the general practice of medicine and surgery is to progress, there must be a certain amount of experimentation carried on; but such experiments must be done with the knowledge and consent of the patient or those responsible for him, and must not vary too radically from the accepted method of procedure.

See generally Kidd, *Limits of the Right of a Person to Consent to Experimentation on Himself*, 117 SCIENCE 211 (1953); Ladimer, *Ethical and Legal Aspects of Medical Research on Human Beings*, 3 J. PUB. L. 467, 487 (1954); Note, *Experimentation on Human Beings*, 20 STAN. L. REV. 99 (1967).

99. V. MARK & F. ERVIN, *VIOLENCE AND THE BRAIN* (1970); Mark, Sweet & Ervin, *The Effect of Amygdalotomy on Violent Behavior in Patients with Temporal Lobe Epilepsy*, in *PSYCHOSURGERY: PROCEEDINGS OF THE INTERNATIONAL CONFERENCE ON PSYCHOSURGERY*, 2d, COPENHAGEN, 1970, at 135, 153 (E. Hitchcock, L. Laitinen, & K. Vaernet, eds. 1972); Mark, *Brain Surgery in Aggressive Epileptics*, 3 THE HASTINGS CENTER REPT. (Feb. 1973); CENTER FOR STUDY AND REDUCTION OF VIOLENCE, NEUROPSYCHIATRIC INSTITUTE, *PLAN OF PROGRAM*, JULY 1, 1973-JUNE 30, 1974 (U.C.L.A.).

100. See, e.g., *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973); CAL. PENAL CODE §§ 2670-2680 (West Supp. 1976); Statement of Alvin J. Bronstein, National Prison Project of ACLU Foundation, *Hearings on H.R. 3603 Before Subcomm. on Courts, Civil Liberties and the Administration of Justice, House Comm. of the Judiciary*, 94th Cong., 2d Sess. (unpublished); HEW regulations for protection of human subjects, 45 C.F.R. § 46.101 *et seq.* (1975); National Research Service Award Act of 1974, Pub. L. No. 93-348, Title II, § 201-205, (July 12, 1974) 88 Stat. 348-51, U.S. CODE CONG. AND AD. NEWS, 386 (1974) (creating a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and standards therefor).

*Kaimowitz v. Department of Mental Health*, the court moved in this direction by determining that experimental behavior control modalities require more judicial scrutiny than do established therapeutic modalities.<sup>101</sup>

These legal developments in the area of human experimentation have created mechanisms which seek to assure that no psychosurgery or other behavioral research proceed without the consent of the subject.<sup>102</sup> Recently the elements of consent to experimentation have developed along the lines of the Nuremberg formulation, which defined three separate elements: knowledge, voluntariness, and competence or capacity.<sup>103</sup> This formulation has been generally followed by the courts and legislative bodies.<sup>104</sup>

The *Kaimowitz* court took the position that involuntarily detained persons are *not capable* of giving informed consent as defined by the Nuremberg Trials. Because of the effects of institutionalization and the daily control over the lives of inmates, the court concluded that neither the knowledge, volition nor competency tests can be met in securing the consent of confined persons:

Although an involuntarily detained mental patient may have a sufficient I.Q. to intellectually comprehend his cir-

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101. Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973), *excerpted in* 2 PRISON L. RPTR. 433, 476 (1973); Note, for example, the court's distinction:

We do not agree that a truly informed consent cannot be given for a regular surgical procedure by a patient, institutionalized or not. The law has long recognized that such valid consent can be given. But we do hold that informed consent cannot be given by an involuntarily detained mental patient for experimental psychosurgery.

102. For example, the California legislature has prohibited the use of psychosurgery except where the subject has given informed consent. CAL. WELF. & INST. CODE § 5325 *et seq.* (West Supp. 1976). Recent amendments to the California law prescribe in detail the procedure to be followed in obtaining consent to psychosurgery and shock therapy. For an extensive analysis of this bill before it became law, see Comment, *Informed Consent*, *supra* note 2; Comment, *Legislative Control of Shock Treatment*, 9 U.S.F.L. REV. 738 (1975). AB 1032 was a follow-up measure in response to the litigation concerning AB 4481. We might mention that AB 4481 was itself patterned initially on a piece of model legislation authored by Darlene Dolan for the Mental Patient Law Project, LAMP, in 1973 [on file at Yale Law School Library].

103. *United States v. Karl Brandt*, TRIAL OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS, Vols. 1 & 2, THE MEDICAL CASE, (U.S. Printing Office, 1948), *reprinted in* J. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 305 (1972).

104. For example, this formulation was adopted by the court in *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973), *excerpted in* 2 PRISON L. RPTR. 433, and as we shall demonstrate, by the California legislature when it adopted CAL. WELF. & INST. CODE § 5325 *et seq.* (West Supp. 1976).

cumstance,. . . the very nature of his incarceration diminishes the capacity to consent to psychosurgery. He is particularly vulnerable as a result of his mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenonemon of "institutionalization".<sup>105</sup>

The implicit coercion of institutionalization and lack of sufficient information about the true nature of the experiments being performed requires that experimentation on confined populations be heavily restricted. It is our position that experimentation on a confined individual creates a strong inference that there has been no consent.

These same considerations frequently apply to non-confined subjects who would submit to psychosurgery or convulsive procedures. Consent has not always been obtained in securing subjects for behavior research. A substantial number of the psychiatrists employing convulsive procedures, which are simpler, less expensive, more accepted and more commonly used than psychosurgery, still do not consider it necessary to obtain the consent of the subject. For example, one physician has written: "In actual fact the occasions when a patient might have to be treated against his will are relatively rare nowadays but do exist. In such circumstances I would not hesitate to treat the patient anyway if I am certain it is necessary."<sup>106</sup> Nevertheless, because we are dealing with mind-altering and essentially experimental modalities, no treatment should proceed until it is legally established that the subject has clearly manifested consent.

### *Consent to "Non-Experimental" Treatments to Alter Mentation*

The constitutional and tort considerations we have expressed must extend to a hypothetical point in time when arguably neither psychosurgical nor convulsive procedures remain experimental.<sup>107</sup> It would seem incumbent upon us to consider what the law should be with respect to the manipulation of

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105. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973), *excerpted in* 2 PRISON L. RPTR. 433, 476 (1973).

106. R. PECK, *THE MIRACLE OF SHOCK TREATMENT* 34-35 (1974).

107. Considering the complexity of the human brain, it may be that expected improvements in the alleged precision of these procedures will in principle be limited or remain insubstantial. The point has yet to be reached where mentation and behavior may be altered with any degree of precision whatsoever, let alone without severe and multiple "side effects."

human mentation when and if available psychotechnologies satisfactorily develop the physical means of altering behavior and mental mechanisms without adverse effects or unintended results.

The *Kaimowitz* court left open for future consideration what should be done should psychosurgery cease to be experimental:

[The] conclusion is based upon the state of the knowledge as of the time of the writing of this Opinion. When the state of medical knowledge develops to the extent that the type of psychosurgical intervention proposed here becomes an accepted neurosurgical procedure and is no longer experimental, it is possible, with appropriate review mechanisms, that involuntarily detained mental patients could consent to such an operation.<sup>108</sup>

We have no quarrel with the *Kaimowitz* position that, should a point be reached when psychosurgery is no longer experimental, people may consent to such an operation. However, if freedom of mentation is a fundamental right, as we believe it is, it follows *a fortiori* that a procedure which seeks to alter mentation cannot be imposed without the informed consent of the individual. Thus, the dispositive factor is not the experimental nature of psychosurgery and convulsive procedures, but rather the constitutional questions which are triggered by the attempt to alter mentation.

We have relied heavily on the concept of consent throughout this article and argued extensively that its presence is the key to administration of procedures affecting mentation; we now turn to an analysis of that concept.

#### INFORMED CONSENT—AN ANALYSIS

It is our position that competency as an element of informed consent is unnecessary and possibly invidious. Before discussing the reasons for this view, we present, as background, the currently accepted rationale for including competency in informed consent and our reasons for taking a contrary view. We then illustrate the potential invidiousness of the competency element via an examination of recently enacted California legislation. Finally, we turn to institutionalized persons

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108. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973) excerpted in 2 PRISON L. REPR. 433, 478 (1973).

and observe how the element of competency serves as a bootstrap denying such persons the right to give or withhold informed consent.

### *The Shapiro Analysis*

In his article *Legislating the Control of Behavior Control*,<sup>109</sup> Professor Shapiro discusses the delicate issue of behavior control achieved by imposition of organic procedures, ostensibly as a means of furthering compelling state interests. We turn briefly to his analysis because it is a well-articulated presentation of a position that has been adopted in legislation.<sup>110</sup> We will then present our objections to this view.

Professor Shapiro establishes that freedom of mentation is a fundamental constitutional right.<sup>111</sup> He then presents arguments, for the purpose of discussion, which support the conclusion that given sufficient proof of a compelling state interest, the law may countenance the use of organic procedures even without the consent of the individual who is to submit to the procedure.<sup>112</sup>

Professor Shapiro views the arguments for the existence of such compelling interests as both "positive"<sup>113</sup> and "negative"<sup>114</sup> in nature. The "positive" argument for legitimately compelling submission to these procedures, even over "competent" refusal, is characterized as enhancement of the personal autonomy of the individual by restoring him or her to sanity. The "negative" approach to legitimately compelling submission to such procedures over competent protest supports the interest of protecting persons and property from an individual who is in an allegedly disordered state. Shapiro rejects what he characterizes as utilitarian arguments for a "negative" approach to the extent they justify imposition of organic treatment over *competent* objection.<sup>115</sup> Since there are other alterna-

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109. Shapiro, *supra* note 3, at 276-96.

110. See, e.g., CAL. PENAL CODE § 2670 *et seq.* (West Supp. 1976).

111. Shapiro, *supra* note 3, at 253-76.

112. *Id.* at 279-80.

113. *Id.* at 282-90.

114. *Id.* at 291-96.

115. *Id.* at 292-93. Shapiro notes that "some researchers in the field of behavior control apparently regard personal autonomy and privacy as passing conventions." Delgado in *Physical Manipulation of the Brain*, THE HASTINGS CENTER REPT. 11 (Spec. Supp. May, 1973), stated, "The inviolability of the brain is only a social construct, like nudity." See B. SKINNER, *BEYOND FREEDOM AND DIGNITY* (1971); Ingraham & Smith, *The Use of Electronics in the Observation and Control of Human Behavior and*

tives, such as confinement, which protect society and do not infringe as intrusively on personal autonomy, Shapiro concludes that constitutional considerations justify the acceptance of a "per se rule against substitution of a person's competent judgment."<sup>116</sup>

Shapiro's per se rule hinges upon the individual being a competent person—one deemed to have the capacity to exercise informed judgment. In the case of a person who is deemed to lack capacity to give consent or to manifest competent refusal to these procedures, Shapiro feels that substitution of judgment and forced treatment may be acceptable, with close scrutiny, a "strict standard of review,"<sup>117</sup> and the "informed adjudication of a court,"<sup>118</sup> based upon either the "positive"<sup>119</sup> or "negative"<sup>120</sup> approach.

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*Its Possible Use for Rehabilitation and Parole, ISSUES IN CRIM.* 35 (1972). Cf., *BEYOND THE PUNITIVE SOCIETY* (H. Wheeler, ed. 1973); Shapiro, *supra* note 3, at 293 n.191.

116. Shapiro, *supra* note 3, at 294.

117. *Id.* at 289.

118. *Id.* at 300.

119. *Id.* at 288-89:

[A]ssume that the patient's illness substantially erodes his capacity to make an informed decision concerning therapy. . . . Suppose the subject . . . lacks the capacity for informed consent and refuses any organic therapy proffered. Our presumption requires us to accord this "disordered" refusal some degree of deference. But most persons, were they to consider the matter at all, would probably consider the presumption overcome when any given decision is thought to be substantially affected by (or in some sense "a product of") mental abnormality. Is this because we think that the consequences of a disordered choice are more likely to be productive of an excess of evil over good than those of a healthy choice? If so, substituted judgment is not only justified, but obligatory on classical utilitarian grounds. . . . Or is it thought that an incompetent person is in some sense "not himself," and that in deference to the ideal of personal autonomy, destructive ventures on his part ought to be prevented at least until, under the influence of treatment or otherwise, "he returns" or "becomes himself" again and can act freely?

. . . .  
Because of a panoply of considerations such as these, *highly disordered thought simply does not rank very high on anyone's list of valuable things or interests.* . . . When the balancing act in a constitutional analysis is performed, then overcoming the presumption protecting disordered mentation and permitting therapy for the purpose of restoring "normal" mentation does not seem terribly difficult.

(Emphasis added).

120. *Id.* at 294: "The proposed legislative alternatives contemplate the imposition of chemotherapy and certain organic conditioning techniques over the protest of persons lacking the capacity for informed consent." Note that in his proposed statutes Shapiro ruled out the use of either psychosurgery or electroshock or other electrical stimulation of the brain on persons lacking in capacity to give informed consent. Shapiro continues:

We disagree. Our position is that no burden of compelling state interest can be met which can overcome the individual's basic right to refuse psychiatric procedures that would alter mentation, effect change in personality and invade the very core of that person's autonomy.<sup>121</sup> Since confinement of violent individuals serves as a less drastic alternative to safeguard other individuals and society generally, the state's interest cannot prevail over that of the individual whose personality and mentation is sought to be altered.<sup>122</sup>

Shapiro adopts an informed consent standard—that no organic procedures begin without the informed consent of the *competent* subject. We depart from Shapiro's approval of substituted judgment in situations where informed consent is not obtainable from a person deemed incompetent. It is our position that *no* organic procedures should be administered unless there is the positive informed consent of the person who is to be subjected to the procedures, and that competency as traditionally conceived should not be an element in the evaluation

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One of the core rationales for this decision, articulated earlier, is that if such capacity is lacking, it may be proper to assert that the person is really making no judgment at all (if the disorder substantially destroys functionality); or if a "judgment" is being made, it isn't really his (he is "not himself"). It was also suggested that a person's disordered judgments (conceding them to be "his") are relatively lacking in value, and so compulsion under such circumstances might not be unjust; the assault on autonomy effected by coerced therapy would be far less than that entailed by ignoring the judgment of one who is competent to decide whether to undergo therapy. . . . [W]e are, by hypothesis, dealing with a person who was thought to be a menace to persons or property, not just himself—and might still be. *In view of the benefits to be secured and dangers to be avoided by imposing organic therapy upon persons lacking such competence, then, the conclusion that the presumption against substitution of judgment is overcome seems fairly persuasive.*

*Id.* at 294-95 (emphasis added).

121. Cf., R. NOZICK, *ANARCHY, STATE, AND UTOPIA* 32-33 (1974):

[W]hy may not one violate persons for the greater social good? . . . Why not . . . hold that some persons have to bear some costs that benefit other persons more, for the sake of the overall social good? But there is no *social entity* with a good that undergoes some sacrifice for its own good. There are only individual people, different individual people, with their own individual lives. Using one of these people for the benefit of others, uses him and benefits others. Nothing more. What happens is something is done to him for the sake of others. Talk of an overall social good covers this up. (Intentionally?) To use a person in this way does not sufficiently respect and take account of the fact that he is a separate person, that this is the only life he has.

122. Cf., J. MILL, *ON LIBERTY* 68 (Pelican ed. 1974): "[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."



of such a consent. The only exception should be emergency cases where there is a clear and imminent danger of immediate fatality unless the procedure in question is performed, and no less drastic measures could avert that fatality.

*A Reexamination of the Established Elements of Informed Consent: Knowledge, Volition, and Competency*

Our disagreement with Shapiro's conclusions stems from a different conceptualization of competency or capacity as a putative element of informed consent. We cannot resolve the problems presented by organic behavior control procedures without a reappraisal of the currently accepted elements of the standard of informed consent.

Because of the fundamental circularity in the conceptual framework of the competency test, the prospective treatment subject is put in a situation from which he or she cannot escape. Competency should be deleted from the informed consent standard, leaving the elements of knowledge and volition as the sole components.

*Knowledge and volition are the necessary elements of informed consent.* The law accepts the waiver of fundamental constitutional rights based upon knowledge and voluntariness where the state seeks to abridge the freedom, or even take the life, of a person. Knowledge—adequacy and understanding of information—and volition—circumstances allowing for freedom of choice—are the twin tests applied to the admission of guilty pleas,<sup>123</sup> admission of confessions,<sup>124</sup> and waiver of essen-

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123. See, e.g., *Boykin v. Alabama*, 395 U.S. 238, 244 (1969) (holding that before receiving a guilty plea, the court must ask the defendant about his intention to plead guilty, must canvass the pleas with the defendant to determine that "he has full understanding of what the plea connotes and its consequences"; must explain the elements of the offense charged, potential defenses, maximum and minimum penalties, and must make an inquiry into the actual facts of the case). See also FED. R. CRIM. P. 11 which provides, in part:

(d) The court shall not accept a plea of guilty or nolo contendere without first, by addressing the defendant personally in open court, determining that the plea is voluntary and not the result of force or threats or of promises apart from a plea agreement. . . .

(f) Notwithstanding the acceptance of a plea of guilty, the court should not enter a judgment upon such a plea without making such inquiry as shall satisfy it that there is a factual basis for the plea.

124. See, e.g., *Miranda v. Arizona*, 384 U.S. 436 (1966) (holding, *inter alia*, that the defendant may waive his several rights—to remain silent, to have the assistance and presence of counsel—provided the waiver is made voluntarily, knowingly and intelligently); *Massiah v. United States*, 377 U.S. 201 (1964).

tial constitutional rights such as the right to counsel in both criminal<sup>125</sup> and civil<sup>126</sup> proceedings. If freedom of mentation is a fundamental right, the same standards should apply when people clearly manifest their desire to forego or undergo treatment affecting that mentation.

*Competency should not be an element of informed consent.* The established elements of informed consent in mental health law are knowledge, volition, and competency. Competency is typically referred to by courts or legislatures as "intelligence" or "judgment." *Parens patriae* notions spawned a protection model for the purpose of "saving" the "mentally disordered" from their own "wrong" decisions. In order to prevent the "incompetent" from harming himself or others, the element of competency or capacity was added to the traditional elements of informed consent.<sup>127</sup> This formulation has been accepted as part of the complete informed consent package by legislators, commentators such as Shapiro, and the Michigan court in *Kaimowitz*. The "protection" afforded by the competency requirement, however, is hazardous, and possibly fatal, to the prospective treatment subject's manifestation of an informed and voluntary decision with regard to the utilization of organic behavior control procedures.

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The courts occasionally use the word "intelligently" to assist in the explanation of the knowledge and voluntariness factors necessary to support the admissibility of a plea or the waiver of any other essential right of the accused. It is our position that the use of the word "intelligently" is superfluous in this context as the courts are in essence applying only the standards of knowledge and voluntariness.

125. See, e.g., *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938); "[C]ourts indulge every reasonable presumption against waiver' of fundamental constitutional rights and . . . we 'do not presume acquiescence in the loss of fundamental rights.' A waiver is ordinarily an *intentional* relinquishment or abandonment of a *known* right or privilege." (emphasis added). See also *Von Moltke v. Gillies*, 332 U.S. 708, 724 (1948) (requiring that no waiver of the right to counsel be accepted unless the court makes the express finding that the defendant apprehends the nature of the charges, that he appreciates the statutory offenses charged, the range of allowable punishment, the possible defenses, the circumstances in mitigation, and "all other facts essential to a broad understanding of the whole matter").

126. See, e.g., *Fuentes v. Shevin*, 407 U.S. 67, 94-96 (1972) (where the Court indicated doubt that there could have been a waiver of procedural due process rights given the nature of the adhesion sales contract involved, but found as a matter of fact that there had been no waiver in any event); *D.H. Overmeyer Co. v. Frick Co.*, 405 U.S. 174, 187 (1972) (waiver must be "voluntarily, intelligently, and knowingly" made); *Aetna Ins. Co. v. Kennedy*, 301 U.S. 389, 393 (1937) (wherein the court observed in civil, no less than criminal, proceedings, "courts indulge every reasonable presumption against waiver" of constitutional rights).

127. *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1212-19 (1974).

Consent to psychosurgery and convulsive procedures should be reviewed simply for knowledge (understanding based on appropriate information) and volition (an act of will freely made). Elements of "information" which incorporate the medical model of the situation such as "awareness of the nature and seriousness of the condition" introduce an implicit judgmental element which should be avoided.

The addition of the competency element gives authorities the power, based upon personal opinions regarding the advisability of the decision or medical diagnoses concerning "mental illness," to negate a voluntary and knowledgeable decision. Where the negation of a person's informed and voluntary decision is founded upon the relative knowledge of the parties involved, this element of informed consent is reducible to the knowledge criterion and thus adds nothing to the process. Where this negation is based upon a medical diagnosis, it is submitted that the state of the art is not sufficiently developed to constitute a valid substitute for individual judgment. In either case, and further developments in the art or science of psychiatric diagnosis notwithstanding, it is proposed that the individual's *judgment* is precisely what should be sacrosanct (provided the *decision* involved is based on adequate information and is voluntary). The element of "competency" thus constitutes at best an unnecessary and perhaps an invidious component of any consent standard which might be employed in such cases.

The inappropriateness of competency as an element in the informed consent standard is underscored when we consider the fundamental disagreement among members of the psychiatric and social science community.<sup>128</sup> The underlying consideration in whether or not to proceed with psychiatric procedures is based on a concept of "mental illness" reflecting the predominant, but hardly the universal, professional view.<sup>129</sup> Since there is wide conceptual disagreement within these disciplines as to the appropriateness of a positivistic medical model, and hence the legitimacy of labeling individuals as "mentally ill," "mentally disordered," "incompetent," or "incapacitated," it is inappropriate for the law on the basis of such conceptions to countenance compelled administration of organic procedures

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128. See text accompanying notes 8-16 *supra*.

129. See *Blocker v. United States*, 288 F.2d 835, 860 (D.C. Cir. 1961) (Burger J., concurring).

which affect the very core of the individual.

Dean Alexander and Professor Szasz argue that no treatment for mental disorder should proceed without contractual agreement between the patient and the person offering treatment, and that no valid agreement can be made without the patient giving consent which is in every sense informed.<sup>130</sup>

If the law is to accord to individuals the opportunity to determine for themselves whether to submit to organic procedures which seek to alter their personalities (and we have argued above that the Constitution and tort law allow nothing less),<sup>131</sup> then the sole concern must be whether the treatment subject understands fully what is proposed, what may happen, and what is the intended result, and voluntarily expresses his desire to undergo the proposed procedures.

### *Informed Consent Under Recent California Legislation*

A brief analysis of recent California legislative efforts to regulate the utilization of psychosurgical and compulsive procedures serves to illustrate the proposition that the inclusion of the competency element in consent threatens rather than protects the rights of persons subjected to organic procedures.

In the summer of 1976, AB 1032 was signed into law amending sections 5325 and 5326 of the California Welfare and Institutions Code. The amendments provide that the informed consent of the prospective subject is a condition precedent to the administration of psychosurgical and convulsive procedures.<sup>132</sup>

Section 5326.5(a) now states that the giving of written informed consent is indicated when "a person knowingly and intelligently, without duress or coercion clearly and explicitly

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130. Alexander & Szasz, *supra* note 52, at 537. As an interesting aside, Szasz and Alexander point out that the early psychotherapists such as Janet and Freud never proceeded except with the consent of their patients:

[They] pioneered not only in practicing a novel type of psychiatric treatment, but more significantly [based] their contact with their clients on a contract with them rather than with their surrogates (familial or judicial). In short, they treated their mental patients *as if* they were "sane" enough to be accorded the dignity of entering into a binding contract with them. It is for this reason that we view the early psychoanalysts as humanists and liberators; while their contemporary "liberal" followers who do not hesitate to coerce where they cannot contract must be viewed in the opposite light.

*Id.* at 554.

131. See text accompanying notes 26-51 *supra*.

132. 1976 Cal. Legis. Serv., ch. 1109 at 4680, amending CAL. WELF. & INST. CODE § 5325 *et seq.* (West Supp. 1976).

manifests consent to the proposed therapy . . . ."<sup>133</sup> At first glance this standard for informed consent might appear to be comprised of only two elements: knowledge ("knowingly") and volition ("without duress or coercion"). A third element, however, is added by introduction of the notion that the alleged consent must be "intelligently" made. Unless the word is deemed redundant or superfluous (and there is no clear evidence to support such a conclusion), its addition to the requirements of knowledge and volition may logically be taken to mean that a third, somewhat nebulous, but nonetheless critical element is being added to the consent standard.

A fair reading of this ambiguous element in the consent standard is that it provides a mechanism whereby a person's *judgment* may be deemed inadequate or impaired in some sense, even though adequate information has been supplied to and understood by the prospective treatment subject, and a decision meeting legal standards for voluntariness has been made. Thus, an individual who possesses adequate information as to the decision in question, and who exercises voluntary choice in making that decision, may still be found not to have acted "intelligently."

This reading of the new law is supported by another section which provides that no informed consent can be given when the person lacks capacity to consent (or to refuse to consent). Capacity is defined as the ability to "understand or knowingly and intelligently act upon the information" which the attending physician must communicate to the person.<sup>134</sup> It may be presumed that "understanding" as a criterion is simply an aspect of the standard for knowledge. To wit: an accurate ingestion of information by the prospective subject would constitute knowledge or understanding. These two uses of the word "intelligence" in AB 1032, however, constitute the double-edged sword which is herein designated as the putative third element of consent—competency.

Presumably this element may be construed as a protection for the prospective subject. However, it could also be employed to deny the validity of a refusal of psychiatric intervention or to deny the validity of a putatively "incompetent" consent to

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133. *Id.*, § 6, at 4683-84, amending CAL. WELF. & INST. CODE § 5326.5(a) (West Supp. 1976).

134. *Id.*, § 6, at 4684, amending CAL. WELF. & INST. CODE § 5326.5(c) (West Supp. 1976).

treatment. The point in either case is that introduction of this element of judgment, designated in this case as "intelligence," may mean that, although an individual has knowledge of the relevant factors involved in the choice before him or her and exercises an apparently voluntary decision with regard thereto, the designated authorities are provided with the power to conclude that the person in question "does not know what he is doing" and to act on that conclusion.

The consent standard incorporated in this new legislation provides extensive and specific disclosure requirements to assure that adequate information is supplied to the prospective treatment subject. Thus the treating physician must clearly and explicitly communicate to the patient:

(a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.

(b) The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.

(c) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(d) The nature, degree, duration, and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.

(e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.

(f) The reasonable alternative treatments, and why the physician is recommending this particular treatment.

(g) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.<sup>135</sup>

This extensive list, if administered by the treating physician with a minimum of medical and psychiatric jargon, in the spirit the legislature intended, should provide the patient with an adequate informational basis for making the decision. All of the components of this list, with the exception of subsection (g)

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135. *Id.*, § 3.5, at 4683, amending CAL. WELF. & INST. CODE § 5326.2 (West Supp. 1976).

are apparently intended to provide the prospective treatment subject with information relevant to his or her decision regarding the proposed procedure.

Subsection (a), however, is further evidence of the implicit judgment element included as a component of the test for informed consent. It is precisely the judgment of the treatment subject which is at issue in determining his or her putative ability to understand "the nature and seriousness" of the alleged "illness, disorder or defect." Presumably, a person is not seriously "ill" if he or she can express this degree of what, in the professional jargon, constitutes "insight into his or her condition." On the other hand, a person who is deemed unable to understand (or who refuses to agree to) the physician's interpretation of his or her alleged "illness" is deemed incompetent to manifest valid consent or refusal, notwithstanding the presence of voluntariness and adequate knowledge. The person, though informed, becomes a candidate for non-voluntary treatment.

Under the new law, if the patient cannot give informed consent, there can be no psychosurgery.<sup>136</sup> Convulsive procedures, however, can be imposed over the objections of a person, institutionalized or not, upon a finding of lack of capacity to give or withhold consent and when consent is obtained from a designated third party.<sup>137</sup> We believe that this third party consent is not a legitimate consent. Freedom of mentation is a fundamental right, a *personal* right. When the alteration of mentation is at issue, the right cannot be transferred or substituted.

### *Are Institutionalized Persons Ever Capable of Consent?*

In an attempt to prevent abusive experimentation on prisoners, the *Kaimowitz* court wrestled with the question of whether truly informed consent could ever be obtained from institutionalized persons. It was essential to make such a determination in that case because an inmate had signed a very explicit consent to psychosurgery,<sup>138</sup> although some time later,

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136. *Id.*, § 7, at 4684-85, amending CAL. WELF. & INST. CODE § 5326.6 (West Supp. 1976).

137. *Id.*, § 8, at 4685, amending CAL. WELF. & INST. CODE § 5326.7 (West Supp. 1976).

138. The complete "Informed Consent" form signed by John Doe was quoted in *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973) excerpted in 2 PRISON L. RPTR. 433, 434 n. 5 (1973). The consent acknowledged that conventional treatment had not enabled him to control his outburst

having been released from the institution, he repudiated that consent.<sup>139</sup> The Michigan court concluded that because the subject was institutionalized, he was not competent to give informed consent.<sup>140</sup> On the facts of that case, we agree that informed consent was lacking, but for different reasons.

Using the three-element Nuremberg formulation—knowledge, volition and competency—the court correctly found that John Doe's consent could not be considered "voluntary" in the institutional context:

Involuntarily confined mental patients live in an inherently coercive institutional environment. Indirect and subtle psychological coercion has profound effect upon the patient population. Involuntarily confined patients cannot reason as equals with the doctors and administrators over whether they should undergo psychosurgery. They are not able to voluntarily give informed consent because of the inherent inequality in their position.<sup>141</sup>

The court noted that the law has always been solicitous of persons contracting or executing wills under circumstances in which there has been explicit or implicit coercion, or undue influence, and has been most concerned with the voluntariness of, for example, confessions admitted as evidence against the

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of rage and antisocial behavior; acknowledged the general outlines of the operation to be performed, including implantation of certain wires to record electrical activity; acknowledged that if brain disturbance was limited to a small area, that part would be destroyed by electrical current; acknowledged that there were a "number of risks" which might be "potentially serious," and the nature of such risks including the possibility that he might not survive the operation; and stated his full awareness of such risks and authorized the clinic and hospital to perform the procedures.

139. *Id.* at 477 n.23.

140. *Id.* at 474.

141. *Id.* at 477. The court also noted:

The Nuremberg standards require that the experimental subjects be so situated as to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching, or other *ulterior form of constraint or coercion*. It is impossible for an involuntarily detained mental patient to be free of ulterior forms of restraint or coercion when his very release from the institution may depend upon his cooperating with the institutional authorities and giving consent to experimental surgery.

The involuntarily detained mental patient is in an inherently coercive atmosphere even though no direct pressures may be placed upon him. He finds himself stripped of customary amenities and defenses. Free movement is restricted. He becomes a part of communal living subject to the control of the institutional authorities.



declarant.<sup>142</sup> The court concluded against this background that no valid consent could be found from the facts before them, because the consent could not have been voluntarily given.

The *Kaimowitz* court also considered the knowledge element of the informed consent standard and further concluded that John Doe could not be construed to have given valid informed consent to psychosurgery,<sup>143</sup> because his having sufficient knowledge hinged on the disclosure and explanation of the treating physicians. Since these physicians themselves did not have the requisite knowledge (as to predictable results, adverse side effects, permanent or semi-permanent damage incidental to the proposed technique) they obviously could not communicate this knowledge to the treatment subject.

Although we have no conceptual problems with the first and second prongs of the *Kaimowitz* analysis, competency as the third, presents serious difficulties:

Although an involuntarily detained mental patient may have a sufficient I.Q. to intellectually comprehend his circumstance . . . , the very nature of his incarceration diminishes the capacity to consent to psychosurgery. He is particularly vulnerable as a result of his mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenomenon of "institutionalization."<sup>144</sup>

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142. *Id.* at 477:

The law has always been meticulous in scrutinizing inequality in bargaining power and the possibility of undue influence in commercial fields and in the law of wills. It also has been most careful in excluding from criminal cases confessions where there was no clear showing of their completely voluntary nature after full understanding of the consequences. No lesser standard can apply to involuntarily detained mental patients.

See also Freund, *Ethical Problems in Human Experimentation*, 273 NEW ENGLAND J. MED. 687-92 (1965):

I suggest . . . that [prison] experiments should not involve any promise of parole or of commutation of sentence; this would be what is called in the law of confessions undue influence or duress through promise of reward, which can be as effective in overbearing the will as threats of harm. Nor should there be a pressure to conform within the prison generated by the pattern of rejecting parole applications to those who do not participate.

See, e.g., *Parker v. North Carolina*, 397 U.S. 790, 799 (1970) (Brennan, J., dissenting); *Brady v. United States*, 397 U.S. 742, 799 (1970) (Brennan, J., concurring).

143. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Wayne County, Mich. Cir. Ct. 1973) *excerpted in* 2 PRISON L. RPTR. 433, 477 (1973).

144. *Id.* at 476.

The competency element in this analysis adds nothing of significance to the strength of informed consent. Carefully analyzed, what the court regarded as factors indicating incapacity can be viewed as knowledge or voluntariness factors. For example, in *Kaimowitz* the court said: "Competency requires the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an intelligent decision."<sup>145</sup> Here, the competency considerations are actually knowledge considerations regarding disclosures made by the doctor and the patient's understanding of what is being undertaken. At another point, the court discusses as capacity what is actually voluntariness:

The fact of institutional confinement has special force in undermining the capacity of the mental patient to make a competent decision on this issue, even though he be intellectually competent to do so. In the routine of institutional life, most decisions are made for patients. . . .

Institutionalization tends to strip the individual of the support which permits him to maintain his sense of self-worth and the value of his own physical and mental integrity.<sup>146</sup>

In this situation, there may necessarily exist explicit or implicit coercion, duress, and overreaching, all of which deal with the element of volition, not competency.

Clearly, the concerns voiced by the *Kaimowitz* court under the rubric of capacity or competency are equally sustainable under the heading of volition or knowledge. The evidence of institutionalization in that case undercuts any finding that the written statement John Doe signed was truly informed consent, not because Doe's confinement rendered him incompetent, but because the fact of institutionalization in that particular case made his "consent" involuntary.

When competency is accepted as an element of consent, and the premise is adopted that no institutionalized person is capable of giving informed consent, the self-determination of institutionalized people is undermined. The result created is exactly the opposite of that which we set out to achieve: the use of nonconsensual organic procedures is prevented—but not

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145. *Id.*

146. *Id.*

because the potential *subject* has made that decision.

Although Professor Shapiro maintains that competency should be an element of informed consent,<sup>147</sup> he insightfully notes the undermining aspect in a rigid rule which declares that prisoners lack the capacity to give "informed consent":

To assume in general that prisoners are not competent to make such decisions would itself risk an erosion of the ideal of personal autonomy. Such an assumption would relegate prisoners as a class to a status in which they would have little chance to prevail against a claimed right of the state to substitute its judgment for theirs even on matters having nothing to do with therapy.<sup>148</sup>

Utilizing the competency standard, even for what appears to be a beneficial end, requires that the law deal with people based upon their status, a path which the Supreme Court has declined to follow in the areas of criminal prosecution<sup>149</sup> and civil commitment.<sup>150</sup> The inherent danger in a finding that institutionalized persons are incompetent to consent to organic behavior control modalities—although this may have the immediate positive result of stopping human experimentation upon confined populations—is that it leads to the conclusion that prisoners and involuntarily confined mental patients lack capacity to make *any* decisions concerning themselves. This inherent danger is avoided if the competency element is eliminated.

The original elements of consent—knowledge and volition—are eminently satisfactory in assuring valid consent to organic procedures which seek to alter behavior and mentation. If a court, in determining whether the consent of a person to a specific procedure is informed, finds before it a person who fails to respond to pertinent questions, or gives answers that indicate lack of understanding of his situation or what treatment is proposed, then on the basis of the criterion of knowledge or information, the court can find that consent is absent. Similarly, if the treatment subject is institutionalized, and the

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147. Shapiro, *supra* note 3, at 307-11. He approves of the following formulation of capacity: "a confined person lacks the capacity for informed consent if he cannot understand, or knowingly, rationally and intelligently act upon, the information concerning, for example, the nature of the therapy and its effect upon his condition." *Id.* at 311.

148. *Id.* at 319.

149. See Robinson v. California, 370 U.S. 660 (1961).

150. See O'Connor v. Donaldson, 422 U.S. 563 (1975).

court finds insufficient evidence that the decision was voluntarily made due to the inherently coercive atmosphere, then on grounds of voluntariness the court can find that consent is absent.

#### CONCLUSION AND A LEGISLATIVE MODEL

We have argued that freedom of mentation as a fundamental right expands the role of the law in the mental health area. No organic procedures which affect mentation, whether they be psychosurgical, convulsive, or other procedures, should proceed without a complete review by a court to determine whether the subject of the organic procedures has given knowing and voluntary consent.<sup>151</sup>

In so determining, the court must look to *factual* matters, and we submit that circumstances of knowledge and volition are factual. Competency and capacity, by contrast, are statements of value or ascriptions of status and are ultimately based on theoretical constructs that the law should not adopt in its determinations regarding the fundamental rights of citizens.

This distinction between factual matters, theoretical constructs and value judgments is underscored by the comments of the federal trial court judge in *Rouse v. Cameron*<sup>152</sup> who could not get the custodians of a petitioning inmate of a mental institution to justify his confinement on any factual basis. The court had repeatedly urged the witnesses for the institution to explain specifically how the patient manifested the claimed anti-social reaction. In evident exasperation at the recital of vague statements and unsupported conclusions, the court said:

I am not going to keep anybody deprived of his liberty on adjectives and generalities, it has got to be verbs and nouns, something that a person does or says that differentiates him from normal people and makes him dangerous. . . . Liberty is too precious to leave it merely with the

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151. The necessity of court review in the area of compelled organic therapy is suggested by Shapiro, *supra* note 3, at 320-24. We go further and suggest that there be no psychosurgery or convulsive therapy without prior judicial approval. The proceeding would be comparable to the acceptance of guilty pleas by criminal courts pursuant to the guidelines for waiver. See *Boykin v. Alabama*, 395 U.S. 238 (1969). Knowledge and volition are inherent elements of the waiver guidelines, thus providing a useful procedural model for determining voluntary, informed consent to utilization of organic procedures.

152. 373 F.2d 451 (D.C. Cir. 1967)

opinions of psychiatrists. . . . [M]atters like these are, in the ultimate analysis, for the court to determine.<sup>153</sup>

*Rouse* involved confinement, but in the context of determining whether informed consent to organic procedures which seek to alter mentation is present, the demand for findings based upon ascertainable facts is equally essential. It is thus imperative that the analysis of informed consent eschew such value judgments and considerations of status as are incorporated in the notions of competence and capacity.

Legislation implementing the concerns we voice in this article is needed to protect the fundamental rights of the prospective subjects of organic procedures designed to alter mentation or behavior, and to shield the professionals performing the procedures from possible liability incurred in the performance of non-consensual or involuntary administration of such organic procedures. Such legislation must require that the treatment candidate be provided adequate information upon which to base an informed choice and must insure that the choice under all the circumstances is clearly voluntary. We would suggest this language:

Section (1): The following information must be directly communicated to the patient with a minimum of medical jargon:

- (a) That the person has the right to refuse the proposed procedure and to revoke consent, orally or in writing, at any time prior to, or in the course of, the procedures;
- (b) A description of the procedure;
- (c) The possible benefits of the procedure;
- (d) The material risks and adverse effects of the procedure, and the extent to which these risks and effects may be irreversible, taking into consideration the person's present physical condition, past and present illnesses, possible pregnancy, use of other drugs, previous reaction to the proposed procedure, and any other circumstances that a reasonably prudent physician would take into account;
- (e) The degree of uncertainty of the benefits and hazards associated with the procedure;
- (f) That there exists a diversity of medical opinion as to the efficacy and the effects of the proposed procedure;
- (g) In the case of psychosurgical and convulsive proce-

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153. *Rouse v. Cameron*, transcript of proceedings (D.C. September 13, 1965), as quoted in J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, *PSYCHOANALYSIS, PSYCHIATRY AND THE LAW* 603, 604 (1967).

dures, the likelihood that the procedure will impair the memory of the person consenting to the procedure;

(h) In the case of psychosurgical and convulsive procedures, that consent shall be for a specified number of procedures over a specified period of time, not to exceed 30 days. Additional procedures in number or time shall require written informed consent;

(i) That the person may take legal action against the treating physician if his or her rights as defined in these sections are violated;

(j) That the person waives all rights of action against the treating physician for any acts reasonably performed in accordance with the person's express consent.

The bill should define informed consent in terms of *knowledge* and *volition* only, eliminating value laden and theoretical competency considerations:

Section (2) Definition, Informed Consent:

(a) An informed consent is one which is knowingly made, without duress or coercion, and clearly and explicitly manifested in writing by the person to receive the procedure;

(b) No organic procedure may be administered to any person in the absence of his or her informed consent, *provided* that a physician, spouse, relative or guardian may petition a court of competent jurisdiction for an order to impose convulsive procedures where evidence is presented, and specific findings of fact made, that a clear and imminent danger of immediate fatality exists, that convulsive procedures would prevent loss of life, and that no less drastic measures would avert fatality.

(c) In a proceeding brought pursuant to section 2(b), the necessity to impose convulsive procedures shall be proven by the petitioning party beyond a reasonable doubt.

This legislative proposal and the arguments advanced in this article are not intended, and will not function, to interfere unduly with the contractual doctor-patient relationship, nor with the rights of any individual to pursue a course of action he or she feels to be in his or her best interest. Such interventions by the state into the private lives of individual citizens are not legitimate. However, given the fundamental nature of the interests involved, and the present attitudes of some members of the psychiatric community regarding non-consensual but "needed" treatment, such legislation is necessary to insure that organic procedures are administered strictly on a consensual-contractual basis.

